

MATERNITY CARE PROGRAM OPERATIONAL MANUAL

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SECTION ONE OVERVIEW

This Maternity Care Program (MCP) Operational Manual is provided as a resource tool. For questions or clarification of program policy or requirements, you may contact the MCP Associate Director.

I MATERNITY CARE PROGRAM AUTHORITY

The Maternity Care Program (hereinafter referred to as MCP) operates on a statewide basis under the federal authority of a 1915(b) waiver. In addition to the guidelines of the waiver, the program is also governed by the existing State Plan, Alabama Medicaid Agency Administrative Code, Alabama Medicaid Provider Billing Manual and the Code of Federal Regulations (CFR). It is the responsibility of the Primary Contractor to be aware of and maintain copies of governing materials.

II DISTRICTS

Primary Contractors for all districts are required to provide maternity care services to all women eligible for the program.

DISTRICT	COUNTIES
1	Colbert, Franklin, Lauderdale, Marion
2	Jackson, Lawrence, Limestone, Madison, Marshall, Morgan
3	Calhoun, Cherokee, Cleburne, DeKalb, Etowah
4	Bibb, Fayette, Lamar, Pickens, Tuscaloosa
5	Blount, Chilton, Cullman, Jefferson, Shelby, St. Clair, Walker, Winston
6	Clay, Coosa, Randolph, Talladega, Tallapoosa
7	Greene, Hale
8	Choctaw, Marengo, Sumter
9	Dallas, Wilcox, Perry
10	Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, Pike
11	Barbour, Chambers, Lee, Macon, Russell
12	Baldwin, Clark, Conecuh, Covington, Escambia, Monroe, Washington
13	Coffee, Dale, Geneva, Henry, Houston
14	Mobile

III RECIPIENTS TO BE SERVED

1. The following recipients who **are** pregnant are required to participate and must be enrolled by the district where the recipient resides:
 - Recipients certified through the SOBRA program
 - Recipients certified through TANF (formerly AFDC) – (aka Medicaid for low income families)
 - Refugees admitted in the country legally
 - SSI eligible women

2. The following recipients **are not** required to participate (these women are also known as systematic exemptions):
 - Dual eligible recipients (Medicare/Medicaid)
 - Illegal undocumented citizens

3. Primary contractors must follow non-discriminatory standards of care, including but not limited to:
 - a. Providing the same standard of care for all Medicaid recipients regardless of the eligibility category.
 - b. Ensuring that no person shall, on the grounds of race, color, creed, national origin, age, health status or handicap, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program of services provided by Medicaid.
 - c. Compliance with Federal Civil Rights and Rehabilitation Acts is required of providers participating in the Alabama Medicaid Agency MCP.

SECTION TWO DEFINITIONS

Anesthesia	Any sensory and/or motor paralysis for the relief of pain including but not limited to; epidural, saddle-block, pudendal block, inhalation central anesthesia, endotracheal anesthesia, etc. which is not medically contraindicated by the attending physician and/or nurse midwife.
Ante-partum Care	All usual prenatal services including, but not limited to, the initial visit at the time pregnancy is diagnosed, initial and subsequent histories, care coordination, risk assessments, physical exams, recordings of weight and blood pressure, fetal heart tones and rates, lab work appropriate to the level of care including hematocrit and chemical urinalysis, and any additional services required for high-risk women.
Benchmark	A standard by which requirements can be measured or judged.
Recipients	Pregnant women, who reside in Alabama, are certified for Medicaid and receive pregnancy-related services under the MCP.
Care Coordination	Management of obstetrical care including recruitment, outreach, psychosocial assessment, service planning, assisting the recipient in arranging for appropriate services including, but not limited to resolving transportation issues, education, counseling, and follow-up and monitoring to ensure services are delivered and continuity of care is maintained.
Clean Claim	A claim that can be processed without obtaining additional information from the provider of service or a third party.
CMS	Center for Medicare and Medicaid Services, a division of the Department of Health and Human Services. CMS was formerly known as HCFA, the Health Care Financing Administration
Continuity of Care	Uninterrupted continual care of the Medicaid recipient that is coordinated to address the health care needs among practitioners and across organizations and time.
Contract Services	See "covered services".
Convicted	A judgment of conviction that has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.
Covered Services	Health care services to be delivered by a Primary Contractor which are so designated in Section Five –Services.
Days	Calendar days unless otherwise specified.
Debarment	Exclusion from participation as a Medicare/Medicaid provider.

Delivery	Vaginal delivery (with or without episiotomy and with or without forceps), or cesarean section delivery. Delivery includes hospitalization, assistant surgeon services, and professional services such as anesthesiology
Delivering Healthcare Professional	An Alabama licensed physician or nurse midwife who is qualified to perform deliveries, prenatal/ postpartum care. DHCP is an abbreviation for Delivering Healthcare Professional.
Disclosing Entity	The entity is a Medicaid provider or a fiscal agent.
District	Geographic division(s) of the State of Alabama as defined by the Alabama Medicaid Agency.
Dropouts	A recipient who begins care in the district of her residence but does not deliver her infant within that district's network. An example of dropout may include someone who moves to another district or miscarries prior to 21 weeks.
Eligible	A person certified as eligible to receive Medicaid benefits and who has been issued a Medicaid identification number.
Eligibility	A process of determination, by Medicaid or an agency specified in the State Plan for Medical Assistance as a certifying agency through a written application, of eligibility for medical assistance.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: <ul style="list-style-type: none"> ▪ Placing the health of the individual (with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy or ▪ Serious impairment of bodily functions; or ▪ Serious dysfunction of any bodily organ or part.
Enrollee	A Medicaid recipient who is currently enrolled in the MCP via her district of residence as further defined in 42 CFR 438.10(a).
Potential Enrollee	A Medicaid recipient who is subject to mandatory or voluntary enrollment, but is not yet enrolled as further defined in 42 CFR 438.10(a).
EOB	Explanation of Benefits – Code(s) appearing on the provider's Explanation of Payment (EOP) to advise of action taken on claims.
EOP	Explanation of payment.
Fee For Service	A method of Medicaid reimbursement based upon payment to providers for services rendered to Medicaid recipients subsequent to, and specifically for, the rendering of those services. Those services that are payable outside the global fees.

Fiscal Agent	The company designated by Medicaid, through contract, to maintain the Medicaid claims processing system.
Fiscal Year	The budget year is defined as October 1 through September 30.
Global Fee	The reimbursement fee paid following delivery to the Primary Contractor for recipients who meet the requirements of the Medicaid MCP. This fee is a lump sum amount paid to the Primary Contractor who, in turn, pays subcontractors who provided services to the particular recipient. The amount paid to each subcontractor is a negotiated amount agreed upon between the Primary Contractor and the subcontractor.
Grievance	An expression of dissatisfaction about any matter other than an action.
Indicator	Measurable dimensions of care (e.g., a medical event, diagnosis, or outcome) to reflect aspects of care the importance of which is gauged by frequency, severity, or cost.
Material Omission	A fact, data or other information excluded from a report, contract, etc. the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.
Maternity Care Primary Contractor	A person, or organization agreeing through a direct contract with the Alabama Medicaid Agency to provide those goods and services specified by contract in conformance with the requirements of the bid and Alabama Medicaid Agency state and federal laws and regulations. PC is an abbreviation that will be used to designate Primary Contractor.
Medicaid	A Federal/State program authorized by Title XIX of the Social Security Act, as amended, which provides Federal matching funds for a medical assistance program for recipients of federally aided public assistance and SSI benefits and other specified groups. Certain minimal populations and services shall be included.
Medically Necessary	Appropriate and necessary services as determined by application of Medicaid medical necessity criteria by health care practitioners and which are rendered to Medicaid Recipients for any condition requiring, according to national or community standards, the diagnosis of direct care and treatment of an illness, and are not provided only as a convenience.
Medical Record	The written record that documents all of the medical treatment and services provided to the Medicaid recipient.
Party of Interest	This is defined as a person or organization with an ownership interest with the Primary Contractor of five percent (5%) or more or in which the Primary Contractor has ownership interest of five percent (5%) or more.

Performance Measure	A consistent measurements of service, practice, and governance of a health care organization. Measurements shall produce solid, statistically based measurement information of critical processes that in turn shall permit the organization to make solid decisions about improvements.
Postpartum Care	In-hospital visits, office visits and/or home visits by a physician, midwife or registered nurse with experience or credentials in obstetrics or pediatrics following delivery for routine care through the end of the month of the 60-day postpartum period (e.g. whether the 60 th day is on September 2 nd or September 16 th , the eligibility continues through the end of the month.)
Pre-Term Delivery	Deliveries occurring at 24-34 weeks gestation will be identified as pre-term deliveries.
Program Exemption	Exemption from receiving care from the Primary Contractor generally as a result of medical necessity, travel hardship or Medicaid granted late in pregnancy. This may also apply to individuals enrolled in a private HMO.
Risk Assessment	Medical and psycho-social assessment performed to determine the peri-natal risk status of pregnant women. The purpose of the assessment is to determine the presence of any medical and/or social risk factors.
Quality Assurance	An objective and systematic process that evaluates the quality and appropriateness of services provided.
Process Improvement	Standards of care and service to members, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.
Related Party	A person or organization has, or may have, the ability to control or significantly influence a Primary Contractor, or a person or organization that is, or may be controlled or significantly influenced by a Primary Contractor. "Related parties" include, but are not limited to: agents, managing employees, persons with ownership or controlling interest in the disclosing business or immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities, persons, or organizations
SOBRA Adult	A SOBRA Adult is defined as a woman who is eligible for only pregnancy-related, postpartum and family planning services. These women are eligible until the end of the month in which the 60 th postpartum day falls. These women are also identified as poverty level women.
Subcontract	A subcontract is any written agreement between the Primary Contractor and another party for any services necessary to fulfill the requirements of the Medicaid MCP Provider Agreement.

Third Party Liability (TPL)

Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for covered services furnished to enrollees. The recipient is still restricted to receiving care through the Primary Contractor unless the TPL is an HMO/Managed Care Plan with a restricted provider network, and then a program exemption shall be requested. Primary Contractors are responsible for collecting all third party payments prior to submitting a claim to Medicaid for payment.

Utilization Review

Prospective, concurrent and retrospective review and analysis of data related to utilization of health care resources in terms of cost effectiveness, efficiency, control, quality, and medical necessity.

SECTION THREE ADMINISTRATIVE REQUIREMENTS

I STANDARDS FOR PRIMARY CONTRACTORS

The Primary Contractor must comply with all the provisions of the executed contract, its amendments and referenced materials and shall act in good faith in the performance of the provisions of said contract. The following is a listing of the standards for the Primary Contractor:

1. Demonstrate the capability to serve all of the pregnant Medicaid eligible population in the designated geographical area.
2. Designate a Director or other designee to be available, accessible, and/or on call at all times for any administrative and/or or medical problems which may arise.
3. Require subcontractors providing direct care to be on call or make provisions for medical problems 24-hours per day, seven days per week.
4. Require that all persons including employees, agents, subcontractors acting for or on behalf of the Primary Contractor, be properly licensed under applicable state laws and/or regulations.
5. Comply with certification and licensing laws and regulations applicable to the Primary Contractor's practice, profession or business. The Primary Contractor agrees to perform services consistent with the customary standards of practice and ethics in the profession. The Primary Contractor agrees not to knowingly employ or subcontract with any health professional whose participation in the Medicaid and/or Medicare Program is currently suspended or has been terminated by Medicaid and/or Medicare.
6. Require that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider only serves Medicaid recipients as required at 42 CFR 438.206(c)(1)(i).
7. Establish mechanisms to ensure that the network providers comply with timely access requirements. The primary contractor shall monitor regularly to determine compliance and shall take corrective action if there is a failure to comply. Access requirements are further defined at 42 CFR 438.206(c)(1)(iv)(v)(vi).
8. Comply with all State and Federal regulations regarding family planning services and sterilizations, including no restriction on utilization of services.
9. Require all subcontractors providing direct services to meet the requirements of and enroll as Medicaid providers as applicable
10. Require accurate completion and submission of hospital encounter data claims to support the validity of data used for statistical capitation purposes.
11. Cooperate with external review agents who have been selected by the State to review the Program.

12. Report suspected fraud and abuse to the Alabama Medicaid Agency. In addition, the Primary Contractor must have policies, procedures, a mandatory compliance plan, a compliance officer, compliance committee and training and education for all of their employees. These policies and procedures must comply with all mandatory State guidelines and federal guidelines as specified at 42 CFR 438.608(b)(1).
13. Prohibit discrimination against recipients based on their health status or need for health services as specified at 42 CFR 438.6(d)(4).
14. Ensure that medical records and any other health and enrollment information that identifies any individual enrollee must be handled in such a manner as to meet confidentiality requirements as specified in 42 CFR 438.224. Each Primary Contractor must establish and implement procedures consistent with confidentiality requirements as specified in 42 CFR 438.224.
15. The Primary Contractor is not required to provide, reimburse payment, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds in accordance with 42 CFR 438.102(a)(b). If the Primary Contractor elects not to provide the service, then they must provide the related information to the State so that it can be provided to the recipient.

II FUNCTIONS/RESPONSIBILITIES

The Primary Contractor must comply with all the provisions of the executed contract, its amendments and referenced materials and must act in good faith in the performance of the provisions of said contract. The following is a listing of the functions and/or responsibilities of the Primary Contractor:

1. Provide the pregnant Medicaid eligible population obstetrical care through a comprehensive system of quality care. The care can be provided directly or through subcontracts.
2. Implement and maintain the Medicaid approved quality assurance system by which access, process and outcomes are measured.
3. Utilize proper tools and service planning for women assessed to be medically or psychosocially at risk.
4. Provide recipient choice among DHCPs in their network.
5. Meet all requirements of the Provider Network including maintaining written subcontracts with providers to be used on a routine basis including but not limited to, obstetricians, family practitioners, anesthesiologists, hospitals, and care coordinators. The Primary Contractor must notify the Agency, in writing, of changes in the subcontractor base including the subcontractor's name, specialty, address, telephone number, fax number and Medicaid provider number.
6. Maintain a toll-free line and designated staff to enroll recipients and provide program information.
7. Require subcontractors to comply with advance directives requirements.

8. Develop, implement and maintain an extensive recipient education plan covering subjects, such as appropriate use of the medical care system, purpose of care coordination, healthy lifestyles, planning for baby, self-care, etc. All materials shall be available English and in the prevalent non-English language in the particular service area. The Primary Contractor is required to participate in the Agency's efforts to promote the delivery of services in a culturally competent manner including to those with limited English proficiency and with diverse cultural and ethnic backgrounds. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight and/or speech impairments.
9. Develop, implement, and maintain a provider education plan, covering subjects such as minimum program guidelines, billing issues, updates from Medicaid, etc. Provide support and assistance to subcontractors to include at minimum program guidelines, billing issues, updates from Medicaid, etc.
10. Develop, implement and maintain an effective outreach plan to make providers, recipients and the community aware of the purpose of the Alabama Medicaid Agency MCP and the services it offers. The Primary Contractor is refrained from marketing activities as specified in Administrative Code 560-X-37-01(17).
11. Develop, implement and maintain an educational program explaining how to access the MCP including service locations. Materials shall provide information about recipient rights and duties, provisions for after-hours and emergency care, referral policies, notification of change of benefits, procedures for appealing adverse decisions, procedures for changing DHCP, exemption procedures and grievance procedures. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight and/or speech impairments.
12. Develop, implement and maintain a grievance procedure including the appeal process that is easily accessible and that is explained to recipients upon entry into the system.
13. Develop, implement and maintain a system for handling billing inquiries from recipients and subcontractors so that inquiries are handled in a timely manner.
14. Develop, implement and maintain a computer based data system that collects, integrates, analyzes and reports. Minimum capabilities include recipient tracking, billing and reimbursement, data analysis and the generation of reports regarding recipient services and utilization.
15. Give Medicaid immediate notification, by telephone and followed in writing, of any action or suit filed and prompt notice of any claim made against the Primary Contractor by any subcontractor which may result in litigation related in any way to the subject matter of this Contract. In the event of the filing of a petition of bankruptcy by or against any subcontractor or the insolvency of any subcontractor, the Primary Contractor must ensure that all tasks related to any subcontractor are performed in accordance with the Terms of the Agreement.
16. Maintain a complete record for each enrolled recipient, at one location, of all services and identify by recipient name, Medicaid number, date of service, and services provided prior to making payment.

The Primary Contractor must obtain such information from all providers of services. It is acceptable to maintain one medical record and one administrative record (e.g. care coordination billing, etc.).

17. Perform claims review prior to submission to Medicaid for Administrative Review.
18. Advise recipients of services that may be covered by Medicaid that are not covered through the MCP.
19. Promptly provide to Medicaid all information necessary for the reimbursement of outstanding claims in the event of insolvency.
20. Coordinate care from out-of-network providers to ensure that there is no added cost to the enrollee.

III GENERAL

The Primary Contractor is responsible for the management of comprehensive obstetrical care. The success of the MCP is contingent upon the Primary Contractor s' provision of a network of quality caregivers, which enables each pregnant woman served to receive comprehensive obstetrical care. The Primary Contractor must utilize resources such as American College of Obstetrics and Gynecologists (ACOG) Standards, established community practice standards, etc. in the development of program guidelines. It is unlikely that a single Primary Contractor will be able to provide all of the necessary resources to participate in the program. Subcontracts must be developed with other providers (e.g., physicians, hospitals, Health Departments) capable of providing the requisite services. Primary Contractors must have sufficient resources and personnel with necessary education and experience or training to perform the requisite duties and responsibilities.

A. Program Director

Each Maternity Care Primary Contractor must have a full time Director. This person must be available on call 24 hours per day or have arrangements for such coverage. This person shall have the following *minimum* qualifications:

1. A BS or BA degree from an accredited college or university **OR** a minimum of three years of management experience in health care specifically a managed care system.
2. Authority to make decisions and implement program policy.
3. Experience in managing low-income populations.

Any changes in the Director's position must be approved by Medicaid. The Agency must be notified in writing prior to the effective date of the change.

B. Computer System

Primary Contractor must maintain a HIPAA compliant computer system that collects, integrates, analyzes and reports. Minimum capabilities include:

1. Automated recipient tracking.
2. Automated billing and reimbursement.
3. Automated tracking charts of billing and recipient flow.
4. Analysis of data and generation of reports including but not limited to utilization and financial services.

5. Database functionality that includes, but is not limited to storage, analysis, and retrieval of information.
6. The ability to produce provider profiles including current overall recipient counts and the number of Medicaid recipients.
7. The capacity to monitor compliance with the contract standards for projected deliveries per month per Delivering Health Care Professional.

C. Recipient Tracking

1. The recipient tracking database consists of recipient demographics to allow for access to and manipulation of recipients within the Primary Contractor's network.
2. The Primary Contractor is required to maintain an automated tracking system that includes at a minimum the following information:

Recipient Name	Medicaid Number
Address	EDC
Phone Number	Physician
Date of Birth	Care Coordinator
Outcome Status (status codes are: A – Active: meaning currently receiving services, D – Delivered, C – Miscarried, M- Moved, E – Exemption.	
Primary Contractors have the option to develop additional codes.	

IV PROVIDER NETWORK

Primary Contractors must have a delivery system that meets Medicaid standards as defined in this manual and in references and attachments hereto. Primary Contractor shall ensure that this delivery system promotes continuity of care and quality care. Primary Contractor must provide all medically necessary services, as covered services following Medicaid policies and procedures.

- A. For the first 30 days after contract award, the Primary Contractor must offer opportunities for participation to all interested potential subcontractors. The potential subcontractors must meet requirements and be willing to participate as providers according to the guidelines of the Alabama Medicaid Agency MCP. Thereafter, a yearly 30-day open enrollment period is required during the first 30 days of the month of each succeeding contract year. Subcontractors must be willing to adhere to program requirements and accept offered reimbursement for services provided.
- B. Primary Contractors must offer the reimbursement level equivalent to the lowest subcontractor price to all subcontractors. Each Primary Contractor must have written policies and procedures for the selection and retention, credentialing and re-credentialing requirements and non-discrimination of sub-contractors as specified at 42CFR438.214
- C. Primary Contractors are not required to offer participation to potential subcontractors who do not agree to adhere to program requirements nor to those who have been disqualified from participation in any federal program, nor any person convicted of an offense involving Medicaid, Medicare programs. Providers that are willing to adhere to program requirements and who otherwise qualify must be given equal and fair participation opportunities. Complaints of discrimination must be investigated by the Agency.

- D. Primary Contractors must contract with subcontractors who are geographically appropriate (50 miles/50 minutes) to recipients within the district. If there are no in-district providers that would ensure that every recipient meets the 50 miles/50 minutes rule, the Primary Contractor is responsible for establishing a network of providers and may have to pursue contracts with out of district providers.
- E. Primary Contractors must continually monitor the provider network to ensure that the capacity is sufficient to meet the needs of all Medicaid recipients in the district and that availability and accessibility are not hindered.
- F. Primary Contractor shall monitor and evaluate provider performance of all subcontractors to ensure that Medicaid and Primary Contractor standards are met. Such monitoring and evaluation system must include a corrective action system. Primary Contractors shall have a documented monitoring system.
- G. Primary Contractor must notify Medicaid within one working day of any unexpected changes that would impair its provider network. This notification shall include:
 - (1) Information as to how the change shall affect the delivery of covered services, and
 - (2) Primary Contractor's plans for maintaining the quality of member care if the provider network change is likely to result in deficient delivery of covered services.
- H. Primary Contractors shall utilize in-state providers if time/distance or medical necessity is not a factor. Primary Contractors are not required by the Alabama Medicaid Agency to sub-contract with out-of-state providers. However, it is imperative that the network be sufficient to meet the needs of the recipients in the district. If the out-of-state provider is contracted, they are subject to the same regulations that govern in-state providers.
- I. Primary Contractors must not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. This includes providers that serve high-risk populations or specialize in conditions that require costly treatment. If a Primary Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.
- J. In accordance with 42 CFR 438.10(f)(5), the Primary Contractor must make a good faith effort to give written notification of the termination of a contracted provider within 15 days of the receipt or issuance of the termination notice to each recipient who was being seen on a regular basis by that subcontractor.
- K. Delivering Health Care Professionals shall have the option of establishing a limited number of Medicaid recipients that he/she shall accept.

V SUBCONTRACTOR REQUIREMENTS

A. Required Subcontract Language:

- (1) Be in writing;
- (2) Require provider to comply with Standards of Care;
- (3) Require provider to comply with other terms and conditions contained in this bid;

- (4) Contain provider reimbursement provisions;
- (5) Contain a provision specifying that provider must agree that under no circumstances (including, but not limited to, situations involving non-payment by the Primary Contractor, insolvency of the Primary Contractor, or breach of agreement) shall the provider bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against Medicaid recipients, or persons acting on their behalf, for **covered** services, rendered during the term of provider's agreement or sub-contract amount with the Primary Contractor. A provider may charge for non-covered services delivered on a fee-for-service basis to Medicaid recipients. Payment for maternity-related services, not covered by the MCP, does not make the recipient responsible for all of her maternity care. .
- (6) Cover the same time period as the Primary Contractor's contract with Medicaid.
- (7) Subcontracts may only be terminated for cause.
- (8) States that the Primary Contractor is held accountable for any functions and responsibilities that it delegates to any subcontractor.

B. Annual Verification Requirements

The Primary Contractor must annually verify the following:

- 1. That the subcontractor possesses a current Alabama Medical License or certification and licensure as a Certified Nurse Midwife or other appropriate licensure requirements
- 2. That the subcontractor is enrolled as a Medicaid provider.
- 3. That the subcontractor has current hospital privileges (as applicable), in good standing, at a participating hospital within the MCP district.
- 4. That the subcontractor is not currently debarred from participation from Medicare/Medicaid. Primary Contractors are required to notify Medicaid within two business days of the time of occurrence when a disbarred provider is identified. The quarterly sanctions report that is distributed by Medicaid as well as the Debarred Provider List that is maintained at the federal level shall be monitored on an ongoing basis to identify these individuals.

VI OUTREACH

Primary Contractors are responsible for implementing and maintaining a Medicaid approved outreach program to inform and educate Medicaid recipients and the community on the MCP. *The goal is to have all Medicaid eligible women enter care in their first trimester.* The program components include, but are not limited to:

- A Medicaid approved printed material available at a 6th grade literacy level explaining program specifics. Outreach materials must include at a minimum explanations of how to access the Maternity Care Program. Medicaid must approve all outreach and educational material prior to actual usage.
- B. Easily accessible program information available at sites such as hospitals, physician offices, Social Security offices, DHR offices, health departments, community resource centers, etc. Primary Contractors shall utilize the brochure developed by the Agency in community outreach efforts.
- C. Coordination with local communities, other agencies, and service providers to ensure awareness of the program and to identify other services available to meet the needs of the Medicaid recipient.
- D. A system for recipients to receive information and ask questions regarding the MCP.

Review of the Primary Contractor's outreach materials will be done during the annual on-site visit.

VII RECIPIENT EDUCATION

Maternity Care Primary Contractors are responsible for implementing and maintaining a Medicaid approved outreach program to inform and educate Medicaid recipients on the MCP. The Primary Contractor must review and provide the Patient's Rights and Duties form provided by Medicaid as well as other available information to meet the needs of their area. The program components include, but are not limited to:

- A. Basic education, such as importance of early and continuous pregnancy care and the importance of following physician's instructions, and expectations of pregnancy and delivery.
- B. Education regarding danger signs during the pre and post natal period which includes information on when to seek medical care in an emergency situation.
- C. Education on where and how to seek emergency care.
- D. Education regarding nutrition and other components of a healthy lifestyle that are necessary for a good pregnancy outcome. Education regarding availability of newborn care classes, information about the Patient 1st Program and immunization schedules.
- E. Education regarding importance of family planning along with written and oral instructions regarding all forms of birth control. The Family Planning PT+3 materials are provided by Medicaid free of charge. The patient should also be made aware of the Plan First Program.

Review of the Primary Contractor education materials will be done during the annual on-site visit.

VIII SUBCONTRACTOR EDUCATION

Primary Contractors must provide a structured educational component for each subcontractor that participates in the program which includes, but is not limited to:

- A. Program requirements
- B. Billing procedures/claims resolution
- C. Quality management protocols
- D. Training sessions or provider meetings at least biannually or more often as needed to address problems and/or provide updated information

IX BILLING INQUIRIES/CLAIMS RESOLUTION

Primary Contractors are responsible for implementing a system for responding to billing inquiries from recipients and subcontractors. Primary Contractors shall only refer claim inquiries to Medicaid that require an Administrative Review. Attachment One contains examples of common billing scenarios.

The system shall have a mechanism in place to address at a minimum:

1. Inquiries from recipients regarding bills received from subcontractors.
2. Inquiries from subcontractors regarding billing issues.
3. Timely resolution of billing inquiries.
4. Claims review prior to submission to Medicaid for Administrative Review.

The Administrative Review Process is designed as a mechanism for subcontractors to submit claims, through the Primary Contractor, for consideration of payment. The following guidelines apply:

- a. Claims that are received by the Agency from subcontractors will be returned to the Primary Contractor for follow-up.
- b. When claims are sent through the Administrative Review Process they should be documented to meet all claims requirements.
- c. The Administrative Review Form (Attachment Two) must be completed by the Primary Contractor and utilized in order for these requests to be processed.
- d. Any claim over one year old must have a detailed explanation of why time filing limits were not met.
- e. Listed below are items that shall be verified prior to the claims being submitted:

UB-92

Recipient Name
Recipient Medicaid number must be 13 digits
Billing provider name and number must agree
Billing provider number must be 8 characters
The claim must be signed or have signature on file, block # 85
Type of bill in block # 4

HCFA 1500

Recipient Name
Recipient Medicaid Number must be 13 digits
The claim must have the recipient's signature or signature on file, block # 31
Billing Provider Name and Number must agree
Billing Provider Number must be 9 digits
Billing Provider Number must be the group number in block 33
Performing Provider Number must be in block 24 K
Performing Provider Number must be 9 digits
Performing Provider must be associated with the Billing Provider Number
The claim must be signed or have signature on file
Claims with date of service past one year, must have Administrative Review request letter with supporting documentation.

SECTION FOUR ENROLLMENT REQUIREMENTS

I RECIPIENT CHOICE

Recipients shall be allowed to select the Delivering Health Care Professional of their choice at the time of entry (enrollment) into the care system. Primary Contractors must accept all women covered by the program and must not disenroll women from the program except through the exemption process (Refer to Section V, IV). Primary Contractors should be aware of the requirements set forth at 42 CFR 438.56 regarding recipient disenrollment.

Primary Contractors must have written policies and procedures governing recipient enrollment. The following guidelines apply:

A. List Requirements

- A Delivering Health Care Professional (DHCP) List must be available for use in the selection process.
- Current provider listings must be maintained. (NOTE: All listings, forms, etc. must be approved by the Agency prior to use).
- The list must include Delivering Health Care Professional choices available through the provider network listed alphabetically and include:
 - address and telephone number; any physician extenders such as nurse midwives, nurse practitioners, residents in training, or physician assistants;
 - the hospital(s) where the Delivering Health Care Professional delivers; all sites where the Delivering Health Care Professional sees recipients i.e., office, Health Department, satellite clinic; and all sites where prenatal care is provided.
- A weekly updated list is required during the initial award period and up to 30 days after implementation date and during the yearly open enrollment. Otherwise, the list shall be updated on a monthly basis and as changes are made.

B. Recipient Choice Requirements

- A DHCP Choice Form developed by the Primary Contractor or the Agreement to Receive Prenatal Care must be completed and signed by the recipient indicating the patient's DHCP choice. A copy must be maintained by the Primary Contractor and a copy sent to the DHCP.
- A recipient enrolled in the Patient 1st Program may select the same Primary Medical Provider (PMP) if he/she is a **subcontractor for the MCP**.
- The Primary Contractor shall notify the selected Delivering Health Care Professional within five (5) working days (or sooner if possible) of the selection.
- A staffed toll-free line is required to enroll recipients into the MCP program and to provide requested information. The toll-free line must be staffed at minimum during the hours of 8-5 weekdays with an answering machine for after hours.
- All enrollment material must be provided in a manner and format that may be easily understood in accordance with 42 CFR 438.10(b)(1).

C. DHCP Selection Process

Recipients must be advised of the process that is to be used in selecting a Delivering Health Care Professional. This process shall include:

- Recipient is to select the DHCP of her choice for Maternity Care from a list of network providers.
- The staff shall ask the recipient to select a delivering hospital. If the selected DHCP does not deliver at the chosen hospital, the recipient must be provided a list of DHCPs, who deliver at the chosen hospital. She shall then be allowed to select a different DHCP or delivering hospital.
- Advise to the recipient of medical professionals who shall be involved in her care, e.g. nurse midwives, nurse practitioners, on-call physicians, etc. Provide this information in writing.
- **The person enrolling recipients into the MCP must not advise, imply or suggest in any way a choice of DHCPs or delivering hospitals.**
- **If the chosen DHCP has reached his/her maximum caseload, the recipient shall be informed and choose another DHCP from the list of providers.**
- If the second physician also has no slots available, staff must work with recipients to have a physician selected within two (2) working days.
- If the recipient does not want to choose a DHCP on the day of enrollment, then she shall be informed that she shall call back within five (5) working days to choose a DHCP, or the Primary Contractor shall assign a DHCP to her on a rotation basis between other DHCPs on the panel. Recipients shall also be notified of the DHCP, with whom they have been assigned.
- The recipient must sign a form at the time of enrollment or the first encounter visit indicating her choice of DHCP. If the DHCP has multiple care sites, the recipient must select the site where she wishes to go for her care.
- The form must be signed and dated by the recipient and the person enrolling the recipient into the program. The original copy must be maintained in the recipient's chart and a copy must be given to the recipient.
- If the recipient has a specific choice of delivering hospitals, she shall select a physician that utilizes that hospital.
- In the event the recipient refuses to choose a DHCP or fails to choose a DHCP within the designated time frame, the Primary Contractor must assign her to a DHCP based on equivalent distribution among the DHCPs, with available openings to serve additional recipients. This process must include consideration of the distance the recipient lives from the provider and prior relationships, if the Primary Contractor has access to this information.

D. DHCP Notification

- Each recipient's selected DHCP must be notified within five (5) working days of the recipient's enrollment.
- A monthly listing of Medicaid recipients electing to enroll with each DHCP shall be provided to the Delivering Health Care Professional. This list must be provided prior to the first day of each month.

II PROGRAM ENROLLMENT

The following guidelines apply when processing a woman's enrollment into the program:

- A. When a recipient presents for enrollment into the program all appropriate forms required by the MCP must be signed. The original forms must be maintained in the recipient's chart and a copy given to the recipient.
- B. Recipients must be provided with all required information regarding rights and responsibilities, grievance process, and telephone numbers, at the time of enrollment.

- C. The person enrolling the recipient into the program must ascertain if the woman has third party insurance (TPL). If TPL is available, obtain the name of the insurance company, address, phone number, policy number. If possible, ascertain from the recipient what type of coverage the policy provides. Verify the information with the insurance company and/or Medicaid and record all information in the file. Some of this information may be available through the online eligibility systems maintained by Medicaid's Fiscal Agent. *It is vital that this type of information be collected at the beginning of prenatal care.*
- D. Enrollment is defined as the date that the form, Agreement to Receive Prenatal Care, is signed by the recipient. If the delivery has occurred there is no reason to enroll the recipient. A Delivery Only fee may be billed in this instance. A Delivery Only fee consists of eighty (80) percent of the full global amount for the district in which the recipient resides.
- E. Advise the recipient of her ability to change DHCPs, without cause, within 90 days of enrollment or at any time, with cause. Continuity of care shall be stressed at the time of enrollment to encourage the recipient to select a DHCP with which she is comfortable.

III CHANGES IN SELECTION

Guidelines for change of DHCP must include:

- A. Allowing recipients to change DHCPs, without cause, once within the first 90 days of enrolling.
- B. Established internal policies and procedures for changing DHCPs.
- C. Allowing recipients to change DHCPs after the 90 days, with cause, which is defined as a valid complaint submitted to the Primary Contractor in writing explaining why the recipient wishes to change her DHCP.
- D. Tracking of changes in DHCPs. Grievance procedure timeframes must be met.
- E. Complaints of non-compliance with the program policies shall be investigated by Medicaid.
- F. Primary Contractors have the ability to put in place policies regarding recipient selection and/or changes. Such policies; however, must meet the requirements set forth at 42 CFR 438.52(d) and 42 CFR 438.56(d)(e)(g).

SECTION FIVE SERVICES

I GENERAL

A. All maternity care services offered under the contract must be in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under fee-for-service Medicaid. The primary contractors may not arbitrarily deny or reduce these services for any reason including the diagnosis, health status, type of illness, or condition. The Primary Contractors may place appropriate limits on a service on the basis of criteria such as medical necessity, or for utilization control, provided the services furnished can be expected to achieve their purpose as defined in 42 CFR 438.210(a)(2)(3)(i)(ii)(iii)(4).

B. The Alabama Medicaid Administrative Code Rule 560-X-1-.07 states:

“Providers who agree to accept Medicaid payment shall agree to do so for all medically necessary services rendered during a particular visit. For example, if pain management services are provided to Medicaid recipients during labor and delivery, e.g. epidurals, spinal anesthetic, these services are considered by Medicaid to be medically necessary when provided in accordance with accepted standards of medical care in the community. These services are covered by, and billable to Medicaid.

Providers may not bill Medicaid recipients they have accepted as recipients for covered labor and delivery related pain management services.”

C. The Primary Contractors shall require that provisions be made available for a second opinion (if either the recipient or health care professional deems it necessary) from a qualified health care professional within the network, or arrange for a second opinion outside the network at no cost to the recipient as specified in 42 CFR 438.206(b)(3)(4).

D. Out of network providers must coordinate with the Primary Contractor with respect to payment as specified in 42 CFR 438.206(b)(5).

E. Enrollees with special needs shall be allowed to direct access to specialist as specified in 42 CFR 438.208(c)(4).

F. If the Primary Contractor elects to authorize services, the requirements of 42 CFR 438.210(b) shall be met. Refer to Administrative Code, Chapter 45 for further details.

II. EXPANDED GLOBAL FEE

A. Primary Contractors are responsible for all pregnancy related care. This includes high-risk care. The time span of responsibility begins the date that pregnancy is determined and ends the last day of the month in which the 60th post partum day falls.

B. The fee shall include all usual prenatal services appropriate to the risk level of the woman including the initial visit at the time pregnancy is diagnosed.

C. Covered services must be medically necessary and encompass maternity related services as well as those that might otherwise complicate or exacerbate the pregnancy.

D. The Primary Contractor shall receive a fee upon pregnancy outcome (delivery or termination) 21 weeks or later.

E. Fees paid by Medicaid to the Primary Contractor represent payment in full. Recipients must not be billed for any services covered under the MCP.

- F. Services to be provided through the Primary Contractor's network and which are reimbursed as part of the global are: (Attachment Three is a listing of the CPT Codes covered through the global. If there is a question whether a service is covered, please contact the Agency.)

1. Prenatal Visit – Includes the initial prenatal visit as well as any revisits.

a) The **initial prenatal visit** is usually defined by American College of Obstetricians and Gynecologists (ACOG) as an in-depth evaluation of the recipient that includes comprehensive histories, physical examination, risk status determination of the recipient, laboratory tests and appropriate procedures.

Components of an initial visit shall include:

- (a) History: family, medical/surgical, productive, gynecological and nutritional.
- (b) Physical Exam (including, but not limited to) height, weight, blood pressure, assessment of head, neck, breast, heart, lungs, abdomen, pelvis, rectum, extremities, U/A, risk status, fetal heart rate, activity and tones (as appropriate) and provider signature.
 - Laboratory Services appropriate for prenatal care.
 - Other necessary procedures as may be indicated by risk status.

b) **Prenatal re-visits** are defined as a re-evaluation of the pregnancy with on-going risk assessments, repeat laboratory tests as recommended by ACOG and physical examinations as indicated. Counseling services on topics of importance to a maternity recipient shall be incorporated into each revisit. The following components shall be included for a prenatal revisit:

1. Interim history
2. Physical exam (including, but not limited to) weight, blood pressure, fundal height, fetal heart rate and activity (as appropriate), fetal presentation, edema, weeks gestation, U/A, risk status, and provider signature
3. Laboratory tests as indicated.

2. Inpatient Care- the fee includes any and all pregnancy-related hospitalizations (including those for high-risk women) in the ante-partum period, hospitalization for the delivery, and any hospitalization that occurs through the end of the month in which the 60th postpartum day falls. Hospitalization includes all charges which are normally submitted on the uniform billing claim form (UB-92) which includes, but is not limited to: labor room, delivery/operating room, room and board including well baby nursery days, drugs, supplies and lab/radiology services obtained during hospitalization. **In the event that pregnancy-related hospitalization occurs in a hospital, other than a contracting hospital, the following applies:**

- a. Emergency hospitalizations - when emergency hospitalization occurs at a non-subcontracting hospital, the Primary Contractor is to pay the other hospital and attending physician at an amount not to exceed the amount Medicaid would have paid fee-for-service. The non-subcontracting hospital is responsible for notifying the Primary Contractor that a recipient from its District is receiving treatment as soon as practicable. The Primary Contractor shall be responsible for reimbursing pregnancy-related emergency hospitalization services, which are medically necessary.
- b. A Primary Contractor has **the right to have the recipient transferred** to a contracting hospital once the emergency medical condition has been determined to be stable by the physician and the transfer does not represent a danger to the health of the mother or the baby.

- c. Non-emergency hospitalization– when a non-emergency in-patient hospitalization occurs at a non-subcontracting hospital, the Primary Contractor shall not be responsible for reimbursement unless the Primary Contractor referred or gave consent for services to be provided prior to the services being rendered. In these cases, the recipient is responsible for payment of charges incurred.
- d. Medicaid will pay additional medically necessary inpatient days for those who have exhausted their inpatient benefit limit for the stay between the onset of active labor to discharge. An additional two days may be authorized for vaginal deliveries and an additional four days may be authorized for c-section deliveries. If the medical record supports complications, additional days may be granted after medical review. (Please see Extended Days Form in attachments). The hospital requesting the extended days is responsible for the following;
 - 1. An Alabama Prior Review and Authorization Request Form shall be completed and submitted electronically or manually. Refer to Chapter 4 of the Alabama Medicaid Provider Billing Manual (available on the Alabama Medicaid Agency web site)
 - 2. In addition to the standard PA Request Form, the following information shall be included;
 - o Recipient's Age
 - o Hospital admission date
 - o Type of delivery
 - o Date benefits exhausted
 - o Discharge date
 - 3. Additional days for women not participating in the Maternity Care Program must be requested within 30 days of hospital discharge..
 - 4. Additional days for women participating in the Maternity Care Program must be requested within 60 days of hospital discharge..
 - 5. Once the authorization is approved, the PA number is placed on the claim form.
 - 6. The claim with the PA number is submitted through the Primary Contractor for administrative review to the Maternity Care Program

Outpatient hospital care - includes any pregnancy related out-patient recipient hospital visits (not for the purpose of services rendered in the emergency department) or visits to the labor and delivery suite for pregnancy related care (e.g. non-stress tests, and false labor). The contract between the Primary Contractor and hospital subcontractor shall specify the payment arrangement for these services.

4. Ultrasounds - the fee includes both the professional and technical components of medically necessary ultrasounds. The Primary Contractor is responsible for up to seven (7) ultrasounds and has the option to establish a system of authorization for ultrasound services. Ultrasound numbers eight (8) and above may be prior authorized by Medicaid to be paid fee-for-service after review of the recipient's clinical condition. Refer to Attachment Four for Medicaid's current policies/procedures for authorization of ultrasounds.

5. Delivery and Postpartum Care- The fee includes vaginal delivery or cesarean section delivery. No more than one fee may be billed for a multiple birth delivery. Postpartum care includes in-hospital visits, office visits and/or home visits following delivery for postpartum care

through the end of the month of the 60-day postpartum period. The postpartum exam shall be accomplished 4-8 weeks after delivery.

6. Assistant Surgeon Fees - The fee includes assistant surgeon fees for C-section deliveries.

7. Associated Services - The fee includes all services associated with treatment of the pregnancy during the antenatal delivery and postpartum period including as defined in Attachment Three.

8. Lab Fees – The fee includes routine chemical urinalysis, hemoglobin and hematocrit tests. Other lab-work may be billed to Medicaid’s fiscal agent fee-for-service. Attachment 3 defines included lab codes. EXCEPTION: routine lab services other than chemical urinalysis, hemoglobin and hematocrit provided in conjunction with the emergency room visit are billable fee-for-service.

9. Anesthesia Services - The expanded fee includes anesthesia services, performed by either an anesthesiologist, nurse anesthetist, or the DHCP, which is not medically contraindicated. The Primary Contractor shall provide epidurals to Medicaid recipients to the same extent and under the same conditions as epidurals are available to the general public. Attachment Three lists the anesthesia codes which are included in the global fee.

10. Care Coordination Services - The expanded fee includes care coordination. Refer to Section Six for details.

11. Postpartum Home Visit –Home visits must be performed according to the Priority Criteria for Postpartum Home Visits. Refer to Section Six for details.

Section B. Delivery Only Services

- 1) When a woman presents only at the time of delivery, the delivery only fee encompasses the services listed below. The definitions from Section A apply to these components.
- 2) Delivery and Postpartum Care
- 3) In-hospital recipient care services at time of Delivery and During the Postpartum Period
- 4) Assistant Surgeon Fees
- 5) Associated Services During the Delivery and Postpartum Period
- 6) Anesthesia Services
- 7) Care Coordination (as applicable)
- 8) Home Visits

Section C. High Risk Protocols

Each recipient entering the care system must be assessed for high-risk pregnancy status as indicated by the presence of risk factors. Women must be referred to a DHCP qualified to provide high risk care if the assessment reflects a condition that cannot be appropriately handled in routine prenatal care sites. **High-risk care is the responsibility of the Maternity Care Primary Contractor.**

III EXCLUDED SERVICES - SERVICES COVERED FEE-FOR-SERVICE

A general description of those services outside the scope of the expanded fee is listed below. For these services, the provider of service shall bill using the appropriate CPT code using their regular provider Medicaid number. All claims for these services can be sent directly to Medicaid's Fiscal Agent. Services billed fee-for-service include:

- A. Drugs - Family Planning or general drugs (e.g. oral contraceptives or iron pills) prescribed by a provider with a written prescription can be billed fee-for-service. Injections administered by the physician or out patient (recipient) facility can be billed fee-for-service. Drugs which are administered in an in-patient (recipient) setting or ambulatory surgical center setting are included in the fee or delivery only fee. NOTE: Insulin and supplies are covered in certain circumstances. Please refer to the Medicaid Provider Billing Manual.
- B. Lab Services - All lab services except hemoglobin, hematocrit, and chemical urinalysis are outside the fee. Pregnancy tests can be billed fee-for-service.
- C. Radiology - Radiology services, with the exception of ultrasounds, are outside of the fee unless performed during an **inpatient** admission. (NOTE: a non-stress test is considered to be a maternity service; therefore, the procedure is included in the global fee).
- D. Dental - Dental services are covered for eligible recipients certified as children under age 21. These services are billed outside the global fee.
- E. Physician - Physician fees for family planning procedures, circumcision code, routine newborn care code, standby and infant resuscitation code may be billed fee for service. Claims for circumcision, routine newborn care, standby and infant resuscitation may be billed under the mother's name and number.
- F. Family Planning Services - Claims for physician services with a family planning procedure code or indicator may be billed fee-for-service. In-patient (hospital) claims for family planning services **NOT** performed at the time of delivery may be billed fee-for-service. The MCP does not limit or restrict access to family planning services.
- G. Emergency Services – Outpatient emergency room service claims containing a facility fee charge of 99281-99285 and associated physician charges 99281– 99288, may be billed fee-for-service This includes outpatient observation. The MCP does not restrict access to emergency services Routine lab work may be billed at the time of an emergency room service. For information on emergency services refer to 42 CFR 438.206(c)(1)(i).
- H. Transportation – Transportation as allowed under the Alabama Medicaid State Plan may be billed fee-for-service. The Medicaid NET Program covers non-emergency transportation.
- I. Fees for Dropout/Miscarriages –
 - Claims for miscarriages must include a diagnosis code from the following range; 630-635, 637-639. Claims using these diagnosis codes may be billed directly to EDS.
 - If a woman begins care with any districts program, and subsequently moves out of district or miscarries (prior to 21 weeks), she is considered a drop-out.

- The Primary Contractor shall be paid a drop-out fee for these recipients.
- Services for drop-outs may be billed fee-for-service.
- In order for the claims to process, subcontractors must send all claims to the Primary Contractor. The Primary Contractor must complete the Administrative Review Form and forward the claims to Medicaid for action. **The Primary Contractor can bill the drop-out fee directly to EDS.**

Exception: claims for recipients who miscarry prior to 21 weeks may be submitted directly to EDS for payment as long as the claim contains a miscarriage diagnosis either primary or secondary. Claims for services that are provided for a woman who subsequently miscarries that do not have the miscarriage code shall be sent to the Primary Contractor for an administrative review. The PC then sends the forms to Alabama Medicaid, Medical Services Division.

- J. Mental Health - Visits for the purpose of **outpatient** mental health services may be billed fee-for-service.
- K. Miscarriages <21 weeks – Refer to Dropouts.
- L. Referral to Specialists – Office or in hospital visits provided by non-OB specialty physicians (i.e. cardiologists, endocrinologists) for problems complicated or exacerbated by pregnancy can be billed fee-for-service by the provider of service. General/family practitioner nor a peri-natologist is considered a specialty provider.
- M. Program Exemptions – Claims for women who are granted a program exemption may be billed fee-for-service
- N. Non-Pregnancy Related Care – Services provided that are not pregnancy-related are the responsibility of the recipient unless she is entitled to regular Medicaid benefits.

IV PROGRAM EXEMPTIONS

A. PURPOSE

The purpose of a program exemption is to allow a recipient to receive care outside the established MCP District. Requests for exemptions shall be sent to the Maternity Care Program. The Primary Contractor must have policies and procedures describing how exemptions will be handled, including application of criteria.

B. CRITERIA

1. Medical Necessity

If the recipient has a high risk pregnancy that the subcontracting physician believes cannot or should not be treated by the Primary Contractor Network and determines that continuous obstetrical specialty care is needed by an out-of-plan provider, a medical exemption can be requested. A letter from the referring physician or accepting physician shall accompany this request or the referring physician or accepting physician can sign the exemption request form. **Transfers at the time of delivery are not eligible for exemptions.**

The exemption request shall be based on the severity of the condition necessitating the request. A list of conditions that shall be considered for medical necessity exemptions is listed below. This list is not

intended to be all-inclusive and medical justification for additional diagnoses shall be reviewed for consideration of exemption status.

- Seizure Disorder (recurrent or repetitive)
- Diabetes – Poorly controlled, Complicating pregnancy, Maternal Diabetic nephropathy
- Fetal or Maternal Cardiac Disease
- Pulmonary edema
- Systemic Lupus Erythematosus – decompensated
- HIV/AIDS
- Tuberculosis, Active
- Asthma, Severe
- Sickle Cell Disease
- Antiphospholipid Syndrome
- Cancer
- ABO Blood Incompatibility Requiring In utero Fetal Blood Transfusion
- Twin to twin in utero blood transfusion
- Leukemia
- Maternal Morbid Obesity with complications such as uncontrolled hypertension
- Moderate to severe renal disease

If the medical report is for a condition/diagnosis other than the ones listed above, the medical records may be requested.

When the referral to the specialty provider is for one or two visits, and the recipient returns to a subcontractor, the medical necessity exemption shall not be granted. The services provided would be included in the expanded fee.

2. Medicaid Eligibility Granted Late in Pregnancy

When the recipient applies for and receives Medicaid eligibility late in her pregnancy (3rd trimester which starts at 27 weeks and goes through delivery) or after delivery and has been receiving continuous care through a non-subcontracted provider, she may be eligible for a program exemption. The Primary Contractor must maintain documentation demonstrating a significant and UNEXPECTED financial change occurring after 27 weeks (e.g. loss of insurance or loss of job). The Primary Contractor must confirm the date of application.

3. Private Managed Care/HMO

If a recipient has insurance or a managed care plan, the Primary Contractor must maintain a copy of the policy or a letter from the insurer indicating the scope of coverage or that the recipient must use a prescribed provider network.

C. PROCEDURE FOR EXEMPTION

1) The recipient or provider shall request an exemption from the Primary Contractor prior to delivery. **EXEMPTION REQUESTS SHALL NOT BE GRANTED RETROACTIVELY AFTER DELIVERY WITHOUT SUPPORTING DOCUMENTATION.** Attachment Five is the standardized program exemption form which must be utilized.

- 2) Some recipients may not become high risk until delivery and must be transported to a **higher level hospital for delivery**. However, if the Primary Contractor provided all the prenatal care and will provide postpartum care, they are still responsible for billing of the expanded fee and disbursement to the other hospital at an amount not to exceed what Medicaid would have paid.
- 3) For Medical Necessity Exemptions, a letter shall be attached or the exemption request form shall be signed by the attending physician or the accepting provider. If the reason is one of those listed, no additional documentation is required. If the reason is not one those listed, medical record documentation shall be submitted explaining the request.
- 4) Medicaid Granted Late in Pregnancy-- the Primary Contractor shall submit the exemption request and maintain the documentation supporting the request.
- 5) Retroactive Medicaid Award--The Primary Contractor shall submit the exemption request and maintain the documentation supporting the request.
- 6) Private Managed Care/HMO – The Primary Contractor shall submit the exemption request and maintain the documentation supporting the request.
- 7) Denial of a Program Exemption: In the event that an exemption request does not meet specified criteria, the reason for the denial shall be sent to the Primary Contractor explaining why the request was denied. It is the Primary Contractor's responsibility to notify the recipient and provider(s) of the denial in a timely manner. *NOTE: If the recipient or provider feels that the exemption has been wrongfully denied, a revised exemption request providing additional information may be resubmitted.

V SERVICES TO ILLEGAL ALIENS

Services to pregnant (illegal aliens) are not included in the MCP. Women in an "illegal alien" status are only eligible for emergency services defined as the delivery. These women can be defined with an Aid Category of 58 or R6 in the eligibility verification system.

Certification is done through the Medicaid out-stationed eligibility worker. Only the actual provider of service is reimbursed in these cases. For a pregnant woman, only the delivery is covered. There is no reimbursement for prenatal care or postpartum care. If you are contacted by an illegal alien, or someone who is helping an illegal alien, refer them to the out-stationed eligibility worker. All payments for this eligibility category are processed outside the MCP.

The following information from the July 2004 Provider Insider is being provided for information only.

Emergency Services for Non-Citizens

Effective for applications approved on or after July 1, 2004, Medicaid will automate Emergency Services for delivery of newborns to aliens (non-citizens). Pregnant non-citizen applicants may apply for Medicaid before their Estimated Date of Confinement (EDC/due date). If eligible, the recipient (the non-citizen mother) will receive a Medicaid card for delivery services only. If she has a social security number, she will receive a plastic card. If she does not have a social security number she will receive a verification letter with her assigned Medicaid number. Providers may use the Medicaid number on the card or letter at delivery and file claims with EDS as usual.

Medicaid still does not pay for prenatal or postnatal care for ineligible non-citizens. Since children born in the USA are citizens they are awarded Medicaid per normal Medicaid processing. This new procedure will allow the non-citizen to obtain a pseudo Medicaid number for the unborn prior to birth. The delivery services billable through EDS include:

Vaginal Delivery – Up to 2 days inpatient care (CPT 59409)
- After previous c-section (CPT 59612)
- Anesthesia

C-Section Delivery – Up to 4 days inpatient care (CPT 59514)
- After attempted vaginal (CPT 59620)
- Anesthesia

Epidural (CPT 62319) Emergency D & C (CPT 58120)

For any other medical services related to the labor and delivery or other emergencies for aliens (non-citizens) such as automobile accidents, the non-citizen must apply for approval through the Medicaid eligibility worker. Medical bills must be provided as well as hospital records. These medical services must go through Medicaid's Prior Approval Unit to determine if the charger will be paid for by Medicaid. Payments for services other than the delivery services listed above will continue to be manually paid by Medicaid.

Update – Emergency Services for Non-Citizens (provider Insider March 2005)

Miscarriages

Miscarriages are not currently billable electronically. Requests concerning miscarriages for aliens who are not eligible for pregnancy or full coverage Medicaid continue to be processed manually, until further notice. Aliens, who had miscarriages, must continue to present bills timely (within three months) to the SOBRA worker, who determines eligibility; then forwards information to the Central Office for manual processing. Providers will receive a check from Medicaid for miscarriages as well as other alien services approved for reimbursement.

Delivery Services Billable Through EDS

Procedure codes 01967 and 01968 have been added to the list of codes billable through EDS for medical claims.

The Type of Admission restriction for type of admission "1" has been removed for UB-92 inpatient claims.

For CMS-1500 (formerly HCFA-1500) medical claims, the following procedures are covered:

59409 – vaginal delivery only

59612 – vaginal only, after previous c-section

59514 – c-section only

59620 – c-section only, after attempted vaginal, after previous c-section

01960 – vaginal anesthesia

01961 – c-section anesthesia

01967 – neuraxial labor analgesia/anesthesia

01968 – anesthesia for c-section delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)

62319 – epidurals

Form UB-92 inpatient claims, the following per diem is covered:

Up to 2 days per diem for vaginal delivery

Up to 4 days per diem for c-section delivery

Allowable diagnoses codes for CMS-1500 or UB-92:

V270-V279

V300-V3921

650

65100-6593

6571-6573

Allow surgical codes for UB-92 are 740-7499

SECTION SIX CARE COORDINATION/HOME VISITS

A. CARE COORDINATION

I OVERVIEW

An integral part of the medical care delivered through the MCP is Care Coordination. Care Coordination is the mechanism for linking and coordinating segments of a service delivery system to ensure that the most comprehensive program meets the clients' needs for care. It may involve one person or a team that has responsibility for managing, assessing, planning, procuring or delivering, monitoring and evaluating services to meet the identified needs of the client. The approach to care coordination shall vary from case to case.

- A. Care Coordination can be generally defined in one of three ways:
- o A system of activities to link the service system to a recipient;
 - o A balanced system of services; or
 - o A process of ensuring that the recipient moves sequentially through a continuum of services.

In coordinating maternity care, combinations of all three definitions apply.

- B. Care Coordinator responsibilities include, but are not limited to, performing the initial encounter requirements, performing the psychosocial risk assessment, assessing the medical and social needs, developing service plans, providing information and education, and tracking recipients throughout their pregnancy and postpartum period.
- C. Care coordination is a professional skill and must be supported from within the Primary Contractor system. Skills employed by the care coordinator include:
- o Brokerage, including knowledge of inter-agency policy and protocol.
 - o Political skills including assertive advocacy for clients' rights and the abilities to negotiate among service systems .
 - o Community orientation, including the ability to locate, augment, and develop resources including informal helping networks.
 - o Clinical, diagnostic, and therapeutic skills
 - o Rehabilitation, including patience in striving to meet goals established for the pregnant population being served

II REQUIREMENTS

- A. Primary Contractor must employ care coordinators who;
- (1) Meet the following professional qualifications:
- (a) social workers licensed and/or license-eligible for Alabama practice with a BSW or MSW from a school accredited by the Council on Social Work Education (license – eligible social worker(s) must obtain license within 12 months of date of employment as care coordinator);
 - (b) Licensed registered nurse(s) with a minimum of one year's obstetrical experience in counseling, accessing resources, and coordinating care with low-income populations;

- (c) Licensed practical nurses with at least two years obstetrical experience and/or one year experience in counseling, accessing resources and coordinating care with low-income populations;
 - (d) Registered nurses with no obstetrical or counseling experience who have successfully completed a care coordinator training course provided by the Primary Contractor and who must be under the supervision of an experienced care coordinator for at least six months.
- (2) In cases where supervision is required, documentation must indicate the care coordinator is being monitored/audited for compliance.
 - (3) Caseloads for care coordinators cannot exceed 300 cases, at any given time.
 - (4) If a recipient is identified as a high-risk medical/social or both all encounters must be face to face.
 - (5) If the status of the recipient changes, the Care Coordinator is responsible for adjusting the service plan and proceeding accordingly.
 - (6) The Primary Contractor must advise all subcontractors of care coordinator services and must require that the subcontractors make appropriate and timely referrals to the Care Coordinator.
 - (7) The Care Coordinator shall provide the recipient with a business card that provides location and telephone number where the recipient can get in touch with the care coordinator shall any questions arise.
 - (8) Care Coordinators must be located in an area, which provides adequate recipient access and maintains recipient confidentiality. Private offices are preferred.
 - (9) Telephones must be available for use in recipient contacts.
 - (10) Primary Contractors must provide an initial training program for newly hired Care Coordinators prior to them assuming caseload responsibilities.
 - (11) Primary Contractors must have a system for ongoing training of Care Coordinators to include CEU workshops and training specific to this field or Medicaid sponsored workshops.

III ENCOUNTERS

A. Initial Encounter

- (a) Purpose
 1. Each enrollee must receive an initial face-to-face encounter including a psychosocial risk assessment upon enrollment into the MCP. A service plan must be established including specific interventions and desired outcomes. The service plan must target problems identified.
 2. The Care Coordinator must be responsible for tracking of the recipient under the service plan including additional encounters.
- (b) Timeframes
 1. The initial assessment/encounter must occur as soon as possible but no later than the specified time frames below. The encounter/assessment must be done in conjunction with the first prenatal visit.
 2. If recipient enrolls in program at less than 15 weeks gestation, the encounter/assessment must occur no later than 21 calendar days after date of enrollment into the program.
 3. Recipients enrolling at 16-25 weeks gestation must receive an encounter no later than 14 days after the date of enrollment into the program.

4. Recipients enrolling at 26 or more weeks gestation must receive an encounter no later than seven calendar days after the date of enrollment into the program.
- (c) Topics to be discussed at the initial encounter
1. Explanation of the benefits and services available through the Primary Contractor network.
 2. Explanation that services for pregnancy-related care shall be obtained through the Primary Contractor and their subcontractors in order for Medicaid to pay for care.
 3. Explanation of care coordination responsibilities beneficial to the recipient including integration of all medical care and ensuring that other needs are met, i.e., transportation, referral to other agencies such as Public Health for WIC vouchers, etc.
 4. Provide the recipient with written information of name, phone number and location of the Care Coordinator assigned to her.
 5. Provide information regarding location of facilities, hours of service, and locations/telephone numbers for after hours emergency care.
 6. If not already completed, explain and obtain a signature on the forms *Agreement to Receive Prenatal Care (Attachment Six)* and *Recipient Rights and Duties (Attachment Seven)*.
 7. Routine questions must be asked regarding domestic violence. Screening protocols are included in Attachment Eight.
 8. Discuss smoking cessation, alcohol and drug abuse and the detrimental effects for the fetus if the mother continues these habits.
 9. A Psychosocial Risk Assessment will be completed and an individual service plan will be developed based on the assessment and interview with the recipient.

B. 2nd Encounter

(a) Purpose

1. Each enrollee shall receive a telephone call to update and evaluate her case. If risk status is high, Primary Contractor must have a mechanism for more frequent assessments.
2. If the recipient does not have a phone, then the visit shall take place in conjunction with the next prenatal visit.

(b) Timeframe

1. This encounter must be done between 21-26 weeks.
2. This may be accomplished by the Care Coordinator, or other designated nursing personnel.

(c) Topics to be discussed

1. Ensure that risk status has not changed
2. Determine whether additional needs have been identified
3. Determine if needs have been met
4. Re-emphasize healthy lifestyles and encourage, as applicable, smoking cessation
5. Address domestic violence

3. Pre-Delivery Encounter

(a) Purpose

1. Each enrollee must receive a pre-delivery encounter, either face-to-face, or by telephone (at risk must be face-to-face) to ascertain delivery preparation; assess plans for pre-delivery care and discuss family planning options.

2. This may be accomplished by the Care Coordinator or other designated nursing personnel.
- (b) Timeframes
1. This encounter must be done between 32 and 36 weeks gestation.
- (c) Topics to Be Discussed
1. Labor and delivery process.
 2. Ensure pre-admission to scheduled hospital has been done.
 3. Assess transportation needs to scheduled hospital and assist as appropriate
 4. Emphasize the need for pediatric care
 5. Provide information as appropriate for available services such as Patient 1st including the Patient 1st Newborn Choice Form (Attachment Nine)
 6. Explain to the recipient the importance of selecting a pediatrician
 7. Explain to recipient the need for contacting SOBRA out-stationed worker/DHR worker/Social Security worker with information about baby's birth.
 8. Discuss need for postpartum follow-up.
 9. Provide information regarding Family Planning/Plan-First, with re-enforcement on obtaining consent forms as appropriate. *Make a written referral to the appropriate Plan First Case Manager providing the patient's name, Medicaid number and EDC.*
 10. Domestic Violence
 11. Stress appropriate preventive dental procedures for infants. Refer to Medicaid's Smile Alabama Campaign material.

4. Postpartum Follow-up

(a) Purpose

1. This encounter must be a face-to-face encounter to ensure that the enrollee has followed through with postpartum care and to reiterate/assist with family planning options.
2. The Care Coordinator or other designated nursing personnel may complete this encounter.

(b) Timeframes

1. This encounter must be accomplished in conjunction with the 4-8 week postpartum visit.

(c) Topics to be Discussed

1. Ensure compliance with the postpartum checkup.
2. Re-emphasize the importance of and availability of family planning services, use of PT+3 materials.
3. Explain enrollment into the Plan First Program, including follow-up with a Plan First case manager as may be applicable
4. Re-emphasize the importance of pediatric care, including selecting a pediatrician.
5. Re-emphasize the Patient 1st program.
6. Assess for further needs.
7. Healthy lifestyles
8. Domestic Violence
9. Stress appropriate preventive dental procedures for infants. Refer to Medicaid's Smile Alabama Campaign material.

5. Missed Encounters

At least **two attempts** must be made to reschedule/perform required care coordinator encounters. The attempts must be **documented** in the recipient's medical record. Attempt action must be commensurate to the recipient and the required encounter.

IV TRACKING OF CARE COORDINATION VISITS

In an effort to ensure standard tracking of care coordination services provided, the following codes have been established for use by the Primary Contractor. These codes cannot be billed separately.

T1016-U1 1st encounter
T1016-U2 2nd encounter
T1016-U3 3rd encounter
T1016-U4 4th encounter
T1016-U5 All encounters

V OVERSIGHT OF CARE COORDINATION ACTIVITIES

Primary Contractors have the responsibility of maintaining oversight activities regarding the provision of care coordination services. Initial policy must outline the process for oversight activities.

B. HOME VISITS

I Purpose

Home visiting programs can contribute to infant health outcomes improved maternal-infant interaction and improved use of community resources. The purpose of the home visit is assessment, education and referral. The purpose of the post partum home visit is not to provide skilled medical care e.g. wound care; IV meds, etc.

Nursing visits shall include examination of the mother and infant to follow-up on any complications related to the delivery or postpartum; look for signs of problems such as dehydration, infection, etc.; support breast feeding efforts; and provide basic nursing such as jaundice screening. Social worker visits may be used when the reason for the visit shall include: examining personal interactions; looking for signs of abuse or neglect; and helping the family to utilize available community resources.

II CRITERIA FOR POSTPARTUM HOME VISITS

When assessing the need for a home visit, the total course of prenatal care as well as the psychosocial assessment shall be considered. Flexibility shall be granted to all persons involved in the woman's or infant's care to determine the need for a home visit. Appropriate personnel shall be utilized when making the home visit. For example, if the reason for the visit is medical in nature, the nursing personnel shall be used. Criteria have been developed as minimum indications. Professional judgment should be utilized in identifying recipients requiring home visits. The goal is to only see the women who actually need home visits and allow for the flexibility to make follow-up home visits for these women as well.

Initial visits shall be made within 20 days of the date of hospital delivery discharge. This timeframe is to allow the professional flexibility. Follow-up visits shall be scheduled as needed. Our aim is to accomplish more visits for the recipients who need the visits.

A home visit is not required when the recipient and/or baby has seen a medical professional with the stated timeframe unless additional needs are determined.

Each of these criteria shall be utilized as a trigger for a more intensive assessment of the need for a home visit or other interventions. You may use any and all of the guidelines below in determining whether a patient requires a visit.

- a. Under 16 Years of Age (use any and all of the guidelines below)
 - At time of conception
 - Late entry into care (20 weeks gestation and over)
 - Not residing in home with parents or spouse/significant other
 - Grossly over weight or underweight (documentation should support)
 - Not in school
 - Use of tobacco and/or alcohol and/or drugs
 - Transportation issues
 - Lack of support from family or father of baby
 - Any other triggers that may indicate a need for follow-up after delivery
- b. Drug and Alcohol Abuse
 - Self reported
 - Psychosocial assessment
 - Odor of alcohol
 - Observations of track marks and/or bruises from needle use
 - Unexplained late entry into care 20 weeks gestation and over
 - At risk lifestyle (i.e., multiple sex partners)
 - Suspicious behavior such as incessant talking, drug seeking behavior (i.e., narcotics for various pains) glazed eyes, lying, sedated, short attention span, etc.
- c. Mental illness
 - Postpartum depression (it is expected that these women may require a series of visits)
 - Long term history of mental illness
 - Taking psychotropic drugs for mental illness
 - Taking anti-depressants and exhibiting outward signs of depression (i.e., flat affect, depressed mood and thought process, lack of interest in personal appearance, lack of interest in planning for baby's arrival, etc.)
- d. Birthweight 2500 grams or less
 - Prenatal care
 - Previous birth outcomes
 - Smoker
 - Enrolled in a hospital follow-up program
- e. Other

III DOCUMENTATION

Medical records shall be maintained as to the need and outcome of home visits.

IV TRACKING OF HOME VISITS

The following codes have been established to assist Primary Contractors in tracking home visits. These are not separately billable codes but codes to be used internal tracking systems.

- H001 – under 16 years of age
- H002 – Drug & Alcohol Abuse
- H003 – Mental Illness
- H004 – Low Birth-weight
- H005 – Other

SECTION SEVEN PAYMENT FOR SERVICES

I GLOBAL FEE/DELIVERY ONLY FEE

This fee must be billed when the recipient has received total obstetrical care or delivery only, as defined in Section Five, through your program. The recipient must have been enrolled prior to delivery to bill this code. Global fee codes are:

- 59400 – Vaginal birth
- 59410 – Delivery Only vaginal birth
- 59510 – C section birth
- 59515 – Delivery only c/section birth

II DROPOUT FEE

This fee must be billed when the recipient begins care in your program but does not deliver. In order to bill this service the woman must have been enrolled prior to delivery. The procedure code is **99199**.

III SUBCONTRACTOR REIMBURSEMENT

The Primary Contractor must have a HIPAA compliant automated reimbursement system for payments to subcontractors and out-of-plan providers. Payments to subcontractors must be made within 20 calendar days of Medicaid payment and in all cases within 60 calendar days of date of delivery. Payments to out-of-plan providers must be made within 90 calendar days. The only exception is when TPL is involved or when payment is under appeal. Medicaid payment is defined as the date the check-write is deposited in to the provider's account.

Primary Contractors must reimburse DHCPs at no less than 100% of the Medicaid urban rate and Nurse Midwives at no less than 80% of the Medicaid urban rate as of February 1, 2005 for procedure codes **59400- 59622**.

IV STOP LOSS

In cases in which the total bills, based on Medicaid allowed amount and benefit limits exceed \$25,000 per recipient, Medicaid shall assume responsibility for the charges over \$25,000. The Primary Contractor must provide documentation of their total costs. The Agency shall make a lump sum payment for those costs over \$25,000 to the Primary Contractor who in turn shall be responsible for paying actual providers of care.

V SERVICES PROVIDED AND BILLED AS THIRD PARTY LIABILITY (TPL)

Primary Contractors are responsible for collecting all third party payments prior to submitting a claim to Medicaid for payment. Recipients with third party coverage (including COBRA) are required to follow all program guidelines. Global claims must reflect the total payments by the third party carrier. Primary contractors cannot ask maternity recipients to pay any part of the co-pay/deductible. TPL requirements are:

A. Third Party Maternity Coverage

1. Primary Contractors are responsible for collecting all third party insurance information from subcontractors before submitting a request to Medicaid for payment.
2. Subcontractors shall file with the other insurer and report amount collected to the Primary Contractor.

3. If the TPL amount collected is more than the rate agreed on between the subcontractor and the Primary Contractor, then the Primary Contractor shall report the TPL amount that has been agreed on between the Primary Contractor and the subcontractor on the global claim.
4. Primary Contractor's claim shall reflect the total payments as outlined in #2 above or a documented denial from the third party insurer.
5. Denials must be submitted only when the entire claim is denied. If there is a third party payment on any part of the claim, that amount shall be listed on the claim and no denial submitted. If denials are submitted and there is also a payment, the claim may not process correctly.
6. Primary Contractors are responsible for notifying Medicaid's Third Party Division by telephone or by mail using the form in Attachment Ten if they identify that the recipient has third party insurance, and it is not listed on the Medicaid file. Primary Contractors must review eligibility for current TPL information through AVRS or PES prior to submitting claims.
7. Primary Contractors are responsible for sending a quarterly report to Medicaid of recipients, who participated in the program, but no claim was billed to Medicaid due to full payment by the third party carrier. In addition, the Primary Contractor must report cost savings up to the rate specified in #2. Refer to Section Nine for report details.
8. Medicaid shall grant a program exemption for TPL only if recipient is enrolled in an HMO. An HMO is defined as a third party carrier, which requires the individual to utilize a limited network of providers. In many cases these providers do not accept Medicaid.

B. Recipients with third party coverage, EXCLUDING maternity.

1. Primary Contractors may notify Medicaid's Third Party Division if the recipient has TPL but the contract does not provide maternity coverage or maternity coverage is not provided for dependents. (If maternity coverage is not available due to a waiting period, deductible hasn't been met, etc., Medicaid cannot update its records. The provider must obtain a denial and submit it with the claim.)
2. This information may be provided by phone directly to Medicaid's Third Party Division or may be mailed to Medicaid's Third Party Division using the form in Attachment Ten.
3. The phone number for Medicaid's Third Party Division is based on the recipient's last name. *If the last name of the recipient begins with A-G, call (334) 242-5280; H-P call (334) 242-5254; and Q-Z call (334) 242-5279.* If the worker is not available, Primary Contractors may leave information on voice mail. Information which must be left includes: name of caller and phone number, recipient's name and Medicaid number, the name of the insurance company, and the message that the contract does not cover maternity or that recipient is a dependent and dependent maternity benefits are not available.

NOTE: If the recipient's insurance coverage has ended or is about to end and the recipient is eligible for COBRA coverage, Medicaid may be able to pay the recipient's insurance premium to continue coverage during the pregnancy and possibly keep that coverage in force for the newborn shall complications arise. The recipient must follow program guidelines to qualify for COBRA.

Premium payment applications can be obtained from and submitted to Medicaid's Payment Review Section. For further information call (334) 242-3722.

4. Once this information is loaded into Medicaid's TPL file, Primary Contractors may submit claims without having to attach TPL denial.

A. Recipients with third party coverage that has lapsed.

1. Primary Contractors must notify Medicaid's Third Party Division of the actual month, date, and year the policy lapsed.

2. This information may be provided by phone directly to Medicaid's Third Party Division or may be mailed to Medicaid's Third Party Division using the form in Attachment Ten.
3. The phone numbers are the same as listed in B3 above.

VI BILLING INFORMATION

Primary Contractors are to bill all claims to Medicaid's Fiscal Agent utilizing the appropriate CPT code. Please refer to the MCP Billing Manual provided by the Medicaid's Fiscal Agent for detailed information on claim filing.

SECTION EIGHT

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

The Quality Assessment and Performance Improvement (QAPI) is an integral part of the MCP. Through it the adequacy and effectiveness, both in clinical and nonclinical areas, of the program can be addressed. This section outlines the requirements of the program. There are three main facets to the overall QAPI process; Primary Contractor; Medicaid and External Quality Review Organization (EQRO). Each facet has its own unique roles and responsibilities.

I. PRIMARY CONTRACTOR

A. Overall Plan

1. Written, clear, concise and addresses all program requirements including outcomes and processes;
2. Has defined processes for the collection, analyzing of and reporting of data;
3. Identifies areas of concern and allows for implementation of corrective action
4. Correct significant systemic problems that may be identified through internal surveillance (monitoring and evaluation), complaints, or other mechanisms;
5. Uses clinical care and/or practice standards that
 - are based on reasonable scientific evidence and are developed or reviewed by plan providers;
 - focus on the process and outcomes of health care delivery, as well as access to care;
 - included in provider manuals developed for use by providers/subcontractors or otherwise disseminated to providers as they are adopted;
 - address preventive health services;
 - are developed for the full spectrum of populations enrolled in the plan, and for which a mechanism is in place for continuously updating the standards/guidelines.
6. Has sufficient material resources, and staff with the necessary education, experience, or training, to effectively carry out its specified activities.

B. Quality Assurance Committee

Each Primary Contractor shall have a Quality Assurance Committee that delineates an identifiable structure responsible for performing QA functions. This committee or structure has:

1. Regular meetings – The committee meets on a regular basis with a specified frequency to oversee QAPI activities. This frequency is sufficient to demonstrate that the structure/committee is following up on all findings and required actions, but in no case are such meetings less frequent than quarterly.
2. Established parameters for operating – The role, structure, and function of the structure/committee are specified.
3. Documentation – There are records documenting the structure's/committee's activities, findings, recommendations, and actions.
4. Accountability – The committee is accountable to the Primary Contractor and reports to it (or its designee) on a quarterly scheduled basis on activities, findings, recommendations and actions.
5. Membership – There is active participation in the committee from subcontractors who are representative of the health plan's providers. At a minimum, it is composed of the Program Director or designee, an OB/GYN physician and /or a delivering physician who practices as a Family Practitioner, a registered nurse with obstetrical experience, a licensed social worker, and a hospital representative. It is also recommended that a Medicaid consumer be included.

C. Minimum Primary Contractor QAPI Elements

Each Primary Contractor has the ability to structure its individual QAPI process to meet the needs of its service and program requirements. The following are the minimum elements that must be present:

1. Evaluates the enrollment process.
2. Reviews oral and written grievances that may be received from subcontractor and recipients.
3. Utilizes the clinical guidelines set forth in the Plan.
4. Provides for quarterly and annual reporting of QAPI activities.
5. Utilizes information obtained from Medicaid's record reviews.
6. Conducts a minimum of one performance improvement project each contract year. The project must utilize objective quality indicators; implement system interventions; evaluate the effectiveness of the intervention and initiate activities to increase or sustain improvement. The topic of the project will be mandated by the Agency.
7. Detects both under and over utilization of services by subcontractors and recipients.
8. Annual summary report of QAPI activities.
9. Conducts focused studies on areas that need a focused review to gauge effectiveness and outcome.

II STATE REQUIREMENTS

To ensure that the Primary Contractor is meeting program requirements and that the program is achieving its intended outcome, the State must also have a formal QAPI strategy.

A. Overall Plan

1. Have a written strategy formatted with the input of stakeholders and formally approved.
2. Identifies areas of concern and allows for implementation of corrective action.
3. Correct significant systemic problems that may be identified through internal surveillance. (monitoring and evaluation), complaints, or other mechanisms.
4. Provide for feed back to the Primary Contractor and other stakeholders.

B. Minimum State QAPI Elements

The State will conduct the following minimal activities with the assistance of the Primary Contractor.

1. Medical Record Reviews to collect data.
2. Grievances reported to the Agency.
3. Review of Grievances tracked by the Primary Contractor.
4. Oversight of Primary Contractor QAPI activities.
5. Recipient surveys through the REOMB process.
6. Review of utilization and outcome data.
7. On-site reviews to ensure compliance with:
 - compliance with subcontractor payment guidelines
 - network requirement
 - care coordinator requirements
 - outreach and education requirements
 - recipient choice requirements
 - home visit requirements

III EQRO ACTIVITIES

In accordance with 42 CFR 438.310 et al, Medicaid is required to contract with an External Quality Review Organization (EQRO). The EQRO is tasked with being independent of the Agency and the program subcontractors, with demonstrated experience and resources and staff to carry out requisite activities. The EQRO is required to validate performance improvement projects and review compliance with the QAPI plan as set forth, including standards for access to care, structure and operations, and quality measurement and improvement. Optional activities may be added at the discretion of the Agency.

IV CORRECTIVE ACTION

The following standards will apply when the need for corrective action is identified:

1. There must be a written, defined corrective action plan.
2. The plan must be approved by all parties.
3. The plan must include:
 - (a) specification of the types of problems requiring remedial/corrective action
 - (b) specification of the person(s) or body responsible for making the final determinations regarding quality problems
 - (c) specific actions to be taken
 - (d) provision of feedback to appropriate health professional, Providers and staff
 - (e) the schedule and accountability for implementing corrective actions
 - (f) the approach to modifying the corrective action if improvements do not occur
 - (g) procedures for terminating the affiliation with the physician or other health professional or provider
4. There must be an assessment of effectiveness of corrective actions
 - (a) As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.
 - (b) Primary Contractor assures follow-up on identified issues to ensure that actions for improvement have been effective.

V QAPI PROGRAM STANDARDS

The following measures will be used by the State to gauge program effectiveness in addition to the information provided through the performance improvement projects and recipient surveys. The data for the following indicators will be gathered by the Agency unless otherwise specified.

- a. To increase the % of pregnant women enrolled in Medicaid who began prenatal care during the first 13 weeks of pregnancy
- b. To decrease the % of low birth weight babies born to Medicaid mothers
- c. To decrease % of very low birth weight babies born to Medicaid mothers.
- d. To increase the % of women who had live births who had a postpartum visit to a health care provider on or between 21 days and 56 days after delivery.
- e. To increase the % of pregnant women who smoke or recent quitters who received advice to quit smoking from a health professional
- f. To increase the % of Medicaid enrollees who had live births during the past year who underwent the recommended number of prenatal visits (determined by the American College of Obstetricians and Gynecologists).
- g. To increase the % of completed required postpartum home visits to Medicaid mothers.
- h. To increase the % of completed required postpartum home visits that adequately addresses the needs of the Medicaid mother and baby.

- i. To increase the % of very low birth weight babies born at facilities for high-risk deliveries and newborns. (only to know)
- j. To decrease the number of Medicaid mothers who delivered between 22-34 weeks gestation.

VI DELEGATION QAP ACTIVITIES

The Primary Contractor remains accountable for all QAPI functions, even if certain functions are delegated to other entities. If the Primary Contractor delegates any QAPI activities to contractors:

There is a written description of: the delegated activities; the delegate's accountability for these activities; and the frequency of reporting to the managed care organization.

1. The Primary Contractor has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.
2. There is evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

VII COORDINATION OF QA ACITIVITY WITH OTHER MANAGEMENT ACTIVITY

The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QAPI activity, are documented and reported to appropriate individuals within the organization and through established channels.

1. QAP information is used in re-credentialing, re-contracting, and/or annual performance evaluations.
2. Activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.
3. There are a linkage between QA and the other management functions of the health plan such as :
 - (a) network changes
 - (b) benefits redesign
 - (c) medical management systems (e.g. pre-certification)
 - (d) practice feedback to physicians
 - (e) recipient education

VIII GRIEVANCE SYSTEM

The State and each Primary Contractor must implement and maintain a grievance system that includes a grievance process, an appeal process and access to State's fair hearing process. The regulations as specified at 42 CFR 438.228 and 438.400 et al must be followed. The following is a general summation of the requirements.

A. General

1. The system must distinguish between the grievance system, grievance process and a grievance.
2. The Primary Contractor must provide grievance and appeal procedures to all recipients and subcontractors, including recipients' right to a fair hearing.
3. The Primary Contractor must have written policies that document and outline the grievance and appeal process.
4. Primary Contractors must accept grievances either orally or in writing.
5. Primary Contractors must notify subcontractors and recipients in writing of the disposition of the grievance at each level.
6. The Primary Contractor and State must maintain records of grievance and appeals. On a quarterly basis, the Primary Contractor must submit to Medicaid the Grievance log as defined in Section Nine.

B. Grievance System

1. The Primary Contractor must give recipients participating in the program reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TY/TDD and interpreter capability.
2. Acknowledge receipt of each grievance and appeal.
3. Ensure that grievances and appeal are handled in an objective and fair manner.
4. Specific policies and procedures must be available addressing the grievance system including recipient rights; timeframes; assistance availability and the toll-free number to file oral grievances and appeals.

C. Grievance Process

Each Primary Contractor should have a designated individual that can receive the grievance and act to resolve the grievance on behalf of the recipient. These type grievances should be resolved within (10) working days of receipt. If the grievance is of an urgent or immediate action, then it should be acted on within 48 hours.

If the grievance cannot be resolved at this level, then the grievance should be referred to the Grievance Committee. At this point the grievance becomes an appeal.

D. Appeal Process

An appeal is defined as the request for review of an action. An action is defined as the denial or limitation of a service; the reduction, suspension or termination of a previously authorized service, the denial of payment for a service or the refusal of the Primary Contractor or subcontractor to act in a timeframe specified. The following general guidelines apply for the appeal process. Complete requirements can be found at 42 CFR 438.400 et al.

1. A recipient or a provider acting on behalf of the recipient can file an appeal to the Primary Contractor.
2. The appeal must be filed within 45 calendar days from the date of the action.
3. An appeal can be filed orally but must be followed with a written, signed appeal.
4. The Primary Contractor must have written policies governing appeals.
5. Appeals must be resolved within 45 calendar days of receipt. Extensions may be granted if requested by the enrollee.
6. The Primary Contractor must have a documented process for expedited appeals.
7. The State Agency corrects/resolves the appeal.

E. State Fair Hearing Process

If a Primary Contractor takes an action and the recipient requests a state fair hearing, the State must grant a fair hearing. The right to a fair hearing, how to obtain a fair hearing and representation rules must be documented and made available to subcontractors and recipients. The state must reach its decision within 90 days for a standard resolution and within 3 working days for an expedited request.

SECTION NINE RECORDS AND REPORTS

I. RECORD REQUIREMENTS

A. Records

The Primary Contractor must maintain books, records, documents, and other evidence pertaining to the costs and expenses of this contract (hereinafter collectively called the "records") to the extent and in such detail as must properly reflect all net costs for which payment is made under the provisions of any contract of which this contract is a part by reference or inclusion.

The Primary Contractor must make available at its central business office at all reasonable times during the period set forth below any of the records of the contracted work for inspection or audit by any authorized representative of Medicaid, Health and Human Services or their duly authorized representative.

In accordance with 45 CFR §95.621 & 74.164, Primary Contractor must maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program, the Department of Health and Human Services (HHS) for a period of three (3) years from the date of the final payment made by Medicaid to Primary Contractor under the contract. However, if audit, litigation, or other legal action by or on behalf of the State or Federal Government has begun but is not completed at the end of the three (3)-year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the three (3)-year period, the records must be retained until resolution. Subsequent to the contract term, documents must be stored in a bonded storage facility accessible to Medicaid.

A file and report retention schedule must be developed by the Primary Contractor and approved by Medicaid. Primary Contractor must maintain and Medicaid shall approve the retention schedule and all changes.

B. Substitution of Micro-media Records

The Primary Contractor may in fulfillment of its obligation to retain its records as required by this article, substitute clear and legible photographs, microphotographs or other authentic reproductions of such records, after the expiration of three (3) years following the last day of the fiscal year in which payment to the Primary Contractor was made, unless a shorter period is authorized by Medicaid. The State Records Commission approves records retention schedules.

C. Medical Records

Primary Contractor and subcontractors must ensure that a medical record system is maintained within the State of Alabama in accordance with §2091.3 and §2087.8 of the State Medicaid Manual which makes available to appropriate health professionals all pertinent information relating to the medical management of each recipient. All entries on medical records must be written in ink or typewritten and authenticated by the signature or initials of the health care professional.

II REPORTING REQUIREMENTS

A. Report Submission

1. Reports are to be submitted as specified in the description of reports. Reporting periods are based on calendar dates. Due to the contract year, information reported may not reflect a full quarter. Primary Contractor's must submit all available data for the quarter.

2. Primary Contractor must be responsible for timeliness, accuracy, and completeness of reports as defined below:
 - a) Timeliness – Reports or other required data must be received on or before scheduled due dates.
 - b) Accuracy – Reports or other required data must be prepared in conformity with appropriate authoritative sources and/or Medicaid defined standards.
 - c) Completeness – All required information must be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.
 - d) Primary Contractor must agree to be responsible for continued reporting beyond the term of the contract. For example, processing claims and reporting encounter data must likely continue beyond the term of the contract because of lag time in filing source documents by subcontractors.

3. Medicaid requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the terms of the contract. Primary Contractor must comply with all changes specified by Medicaid.

B. Reports

Report Name	Media	To	Timeframe	Due
Service Summary	e-mail	MCP QA	Quarterly	Within 45 days of the end of the quarter being reported
Sale, Exchange, Lease of Property	Paper	MCP	Occurrence	Within 5 days of occurrence
Loans and/or Extension of Credit	Paper	MCP	Occurrence	Within 5 days of occurrence
Furnishing for Consideration of Goods & Services	Paper	MCP	Occurrence	Within 5 days of occurrence
TPL	e-mail	MCP	Quarterly	Within 45 days of the end of the quarter being reported
Organizational structure	Paper	MCP	Annual and upon change	June 1 st and/or within 5 days of occurrence
Provider Network	e-mail	MCP QA	Annual and upon change	June 1 st and/or within 5 days of occurrence
QI Activity	e-mail	QA	Quarterly	Within 45 days of the end of the quarter being reported
Grievance Log	e-mail	QA	Quarterly	Within 45 days of the end of the quarter being reported
QI Meeting Minutes	e-mail	QA	Quarterly	Within 45 days of the end of the quarter being reported

Receipt of reports will be confirmed via e-mail within 3 working days.

B. Report Details

1. Service Summary Report

In accordance with 42 CFR 438.242 Primary Contractors must have a health data system that collects data on utilization, grievances, etc. and collects data on provider and enrollee characteristics as specified by the State on services furnished through an encounter data system or other methods.

To capture recipient and provider specific information, Primary Contractors are required to report the following elements on a quarterly basis:

- Number and type of deliveries
 - Number of deliveries by DHCP
 - Number of deliveries by Hospital
2. Sale, Exchange, Lease or Property; Loans. And/or Extensions of Credit; Furnishing for Consideration
This report enables the Agency to determine the financial stability of the organization and the specifics of the individuals involved.
 3. TPL Cost Avoidance
This report must be provided to Medicaid's Third Party Section. The monies reflected must be used in cost-avoidance totals. The reporting format is included as Attachment Eleven. The reporting form contains directions for completion.
 - 4.. Organizational Structure
This report indicates for the Agency the individuals involved in the Primary Contractor's organization. Significant changes must be reported within 5 days of occurrence.
 5. Provider Network
This report must be reflective of all subcontractors in the Primary Contractors network. Complete demographic information must be included. In addition, the service offered and the Medicaid Provider Number of the subcontractor must be indicated.
 6. QAPI Activity
This report must summarize the Primary Contractors QAPI activities for the quarter. The required format for reporting must be provided during the Contractors Requirement Meeting.
 7. Grievance Log
This report allows the Agency to track issues as they arise as well as assure that each issue is resolved. The required format for reporting is contained in Attachment Twelve.
 8. QI Meeting Minutes
This report allows the QA Division to focus on quality concerns in individual districts and how the Concerns are being resolved. There is no required format.

SECTION TEN MEDICAID OVERSIGHT

I General

The Agency shall monitor Primary Contractor performance to ensure that all contract requirements are being met. Oversight shall be accomplished during the medical record review process, annual administrative review and through reporting requirements.

II Administrative Reviews

Annually each Primary Contractor shall be visited on site. The purpose of the visit shall be to review administrative components of the program including, but not limited to, organizational structure, contracts and subcontracts, care coordination, enrollment activities and home visits.

Primary Contractors shall be given a two-week notice of the visit as well as any documentation requirements.

III Medical Record Reviews

As part of the QAPI, the Agency shall be conducting medical record reviews. The purpose of the reviews shall be to gather information that can be used in the overall evaluation of the Program as well as individual Primary Contractors. As part of the medical record review process, oversight activities may be conducted as well.

Section D. Contract Sanctions

(a) Administrative Measures

In the event that Primary Contractor fails to meet the ITB and contract requirements, and damages are sustained by Medicaid; The Primary Contractor, therefore, agrees to pay Medicaid the sums set forth below as liquidated damages unless these damages are waived by Medicaid.

Medicaid may impose liquidated damages of \$500 per day for the following:

1. Failure to deliver requisite reports/services/deliverables as defined by the ITB by the date specified by Medicaid.
2. Failure to provide documentation as required by the ITB.
3. Failure to perform tasks as specified in the ITB within the time specified by Medicaid, including but not limited to, claims payment.
4. Failure to maintain staffing level required by the ITB.
5. Failure to comply with any other requirement of the ITB.
6. Misrepresents or falsifies information that it furnishes to CMS or to the State. Misrepresents or falsifies information that it furnishes to and enrollee, potential enrollee, or health care provider. Failure to comply with the requirements for physician incentive plans, as set forth (for Medicare) in §§422.208 and 422.210.

In addition,

- Primary Contractor shall be liable for any penalties or disallowance of Federal Financial Participation incurred by Medicaid due to Primary Contractor's failure to comply with the terms of the contract. Total dollars may include state funds as well as federal funds.

- Imposition of liquidated damages may be in addition to other contract remedies and does not waive Medicaid's right to terminate the contract.
- Unauthorized use of information shall be subject to the imposition of liquidated damages in the amount of ten thousand dollars (\$10,000) occurrence.
- Failure to submit an acceptable required corrective action plan shall result in the imposition of liquidated damages in the amount of \$500.00 per day past the date required by Medicaid until such corrective action plan is received and accepted by Medicaid.

(b) Claim Recoupment

Failure to provide requisite services under this ITB shall result in recoupment of claims or the requirement to bill for a lowered level of reimbursement. Primary Contractors shall receive written notice from Medicaid upon a finding of failure to comply with contract requirements, which contains a description of the events that resulted in such a finding. Primary Contractors shall be allowed to submit rebuttal information or testimony in opposition to such findings. Medicaid shall make a final decision regarding implementation of liquidated damages.

(c) Notice and Hearing

Except as provided in §438.7061, before imposing any of the intermediate sanctions specified, the State must give timely written notice that explains the basis and nature of the sanction, and any other due process protections that the State elects to provide.

Before terminating a contract under §438.708, the State must provide the Primary Contractor a pre-termination hearing. The State must give the Primary Contractor written notice of its intent to terminate, the reason for termination, and the time and place of the hearing; after the hearing, written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the termination and information.

After a State notifies a Primary Contractor that it intends to terminate the contract, the State may give the program's enrollees written notice of the State's intent to terminate the contract and allow enrollees to disenroll immediately without cause.

The State must give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in §438.700 within 30 days after the State imposes or lifts a sanction.